LECTURE

The changing relationship between the public and the medical profession

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I started medical school in 1953, almost 50 years ago. The new National Health Service (NHS) was just getting underway, and its founding principle—all citizens should enjoy good medical and health care free at the time of need and irrespective of their ability to pay—had caught the public imagination and the professional idealism of many doctors.

Now, 50 years on, we have a crisis in the NHS and we need to understand why. There are two main issues. There are deep-seated flaws in the culture and regulation of the medical profession and serious deficiencies in the management and capacity of the NHS[1,2].

The cultural flaws in the medical profession show up, in individual cases, as excessive paternalism, lack of respect for patients and their right to make decisions about their care, and secrecy and complacency about poor practice. These all contribute to a picture which leads the public to believe that many doctors put their own interests before those of their patients[3].

The deficiencies in the management and capacity of the NHS have their outward visible signs in the lack of institutional attention to quality and safety—in unacceptable waiting times for treatment, medical and non-medical care of indifferent or poor quality, dirty hospitals, inflexible systems, defensive complaints procedures and so on. There is a serious shortage of doctors. No wonder there is general anxiety about whether the NHS can deliver a service of acceptable quality.

These concerns are shared fully by doctors. I cannot remember a time when so many doctors have felt so angry, undervalued and disillusioned. Public and government criticism of the profession, together with fears of litigation, have added to the demoralizing effect of the treadmill[4]—the relentlessly rising volume of service demands that leaves no proper time for establishing effective relationships with patients or for reflective practice review, both of which are fundamental to good quality.

The General Medical Council (GMC) has been rightly criticized for failings that are of its own making, and has acted as a lightning conductor for more general criticisms of doctors' attitudes. Less justifiably, it has been used as a proxy for some of the underlying institutional failings in the NHS. The 'blame game' is unhelpful, as is the present tendency to seek simple solutions to complex problems. A recent example was the Government's inappropriate linkage of the new National Clinical Assessment Authority with the detection of murder—the Shipman case.

So we have wholesale change again, as the Government, managers and the health professions get to grips with the situation. Such is the plethora of new proposals that many doctors and the public have difficulty making sense of it all.

Here I deal with two issues that are fundamental to the way forward. These are:

- The need to implement the culture and practice of continuous quality improvement and quality assurance across our healthcare system
- The professionalism of doctors—their attitudes and regulation, and how these must change to meet the public's expectations today.

Things do not happen in isolation, so let me begin with the background.

HOW DID WE GET HERE? LESSONS FROM THE PAST

The medical profession as we know it is about 200 years old. Until the middle of the last century it had been harmless and essentially ineffective—comfort more than cure. Now medicine has become hugely more effective, but this has brought its own risks[5].

The NHS was founded in 1948. The circumstances and culture surrounding that event need to be understood because they contributed to the formation of the attitudes and culture that we are trying to change today. We had a new social order at the end of the Second World War—the welfare state. The NHS, like other public services and the newly nationalized industries, adopted the Eastern European 'command and control' model. It was producer dominated—patients had very little say and did not expect it. Queuing and rationing were part of life.

Specialization was a powerful driver. The greatly expanded body of consultants was riding high, since they

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were held in awe by patients and, as a group, saw themselves as the élite of medicine. There was great optimism and public confidence in the new science and technology of medicine. So science and scientific research became embedded at the top of the profession's values and incentive systems, with the so-called 'soft parts' of medicine—notably communication with patients and relatives, and teaching—apparently much less valued. People accepted that. The State, anxious to get consultants to work for the new NHS rather than to continue relying on private practice, decided, as Aneurin Bevan is reported as saying, to 'stuff their mouths with gold'[6]. There was virtually no accountability or strings attached, and the public perception of specialists as omnipotent soon became virtually institutionalized in a steeply pyramidal career structure. This made it more difficult for consultants to admit to fallibility and error—all the more important because they were the teachers and thus modelled the culture.

By contrast, general practice only survived because of the State's statutory duty to provide primary medical care, and there were serious misgivings about its quality and safety. It was regarded by specialists as the dustbin of medicine where, as Lord Moran, the President of the Royal College of Physicians of London said, doctors go who have 'fallen off the ladder'[7]. General practitioners had no vocational training—it was not thought necessary. General practice had no impact upon the culture of medicine. But that was to change.

The State, chronically strapped for cash, encouraged the medical profession to ration care on its behalf through the doctrine of care according to clinical need—in plain language, waiting lists. Doctors, the reasoning ran, would be more trusted by the public than politicians to make decisions on clinical priorities. As a result doctors in the UK retained far more clinical freedom than, for instance, their American colleagues.

This unspoken consensual—some would say collusive—relationship between State and medical profession survived recurring financial crises and repeated reorganizations until the late 1980s. In terms of entrenching attitudes that is a long time. Then Mrs Thatcher's Government turned its attention to health. Mrs Thatcher, sensitive to changing public expectations, signalled that patients and the public had to come first[8,9]. In ending the consensus successive Conservative Governments introduced to the NHS:

- Modern general management
- The first strategy for health
- A competitive internal market to try to decentralize decision-making, secure value for money and achieve better quality
- More explicit accountability for doctors—for example, a statutory requirement for clinical audit for specialists, and a new contract for GPs
- And later, a Patient's Charter.

Thus did the corporate State challenge the medical profession and intrude further into clinical practice and medical education. For both specialists and GPs the contentious issue was the new accountability. For GPs there was a clear division between those who, like myself, saw in 'fundholding' a way of directly developing primary care services and influencing the quality of secondary care, and others who had ethical objections to the purchase of healthcare. However, the difficulties of implementation, particularly the increasing focus on cost containment rather than quality, which demotivated the health professions, led the Conservative administration to lose the plot. 'They know the price of everything and the value of nothing', was the jibe. It was the incoming Labour Government in 1997 which picked up the banner of quality whilst retaining the principles of accountability inherent in the purchaser/provider split and in the spirit of fundholding, which we see today in primary medical services.

So, over the half-century, we have had the following:

- Throughout, a command-and-control model of providing healthcare in the NHS
- For 40 of those years, an employer/producer rather than patient orientation, which contributed substantially to the formation of protective attitudes, sloppy management and the toleration of too much poor practice
- Consequently a medical profession that was too paternalistic and accustomed to defining accountability on its own terms
- Consequent to that, a system of medical regulation which was reactive, inward-looking, unresponsive and (as the profession and management wanted) concerned only with the most flagrant abuses or dysfunction
- Virtually no government or institutional commitment to quality and therefore no realistic investment in the time and other resources needed for quality practice
- Very poor data on performance, and poor information and management systems
- And no adequate investment in the education and professional development of doctors, or indeed of anyone else.

All this was against the background of a population undergoing huge social change. People have acquired higher disposable incomes, expect to be treated with courtesy and respect and want to be more in control of medical decisions affecting their own lives. They are better educated—almost

40% of young people go into higher education—and much better informed with virtually unrestricted access to medical knowledge across the whole world. And all this before we have begun to feel the full social impact of the information revolution.

Let me give a flavour of that change. Holly, a child now completely deaf as a result of badly handled meningitis, has been transferred by her parents from one NHS teaching hospital to another. Although they accept that the results of the cochlea implant procedure are the same in the two institutions, their researches persuaded them that the critical aftercare in one of them is superior. So they insisted on being transferred. They have quickly become expert and assertive members of the public. They are using information available on the Internet. They are calling the shots—not doctors or managers. Actions of this sort are becoming commonplace.

THE EVOLVING QUALITY AGENDA

The foundations of the quality movement in healthcare were laid in the early 1960s in the USA[10,11]. From the inspirational work of Avedis Donabedian (who gave us the concept of structure, process and outcome), founded on a strong public/patient orientation, a huge investment of money, people and talent led to a flood of development. This created the scientific and methodological basis for clinical standard-setting and quality assessment, including clinical guidelines, the outcomes movement and evidence-based medicine. Lately, the Institute of Medicine in the USA launched a national initiative for reducing clinical error by use of methods such as the mandatory reporting of near-misses and critical events pioneered originally in the aerospace industry[12]. Ten years ago Berwick[13] and others adopted the 'continuous quality improvement' approach[14] for healthcare, originally developed for Japanese industry. There is now a huge investment in national data systems needed for comparative measurement and evaluation. Overall the American healthcare system, whatever its other shortcomings, has evolved a very solid foundation of knowledge, expertise and experience upon which we can all draw, in sharp contrast to the picture in this country.

The UK approach to quality has been modest and fragmented, and in the early years was almost entirely professionally inspired. In the hospital service there were confidential inquiries into maternal mortality[15] in the 1950s, and later the CEPOD inquiries into avoidable surgical deaths[16]. More recently the cardiac surgeons have done good work, and the anaesthetists and intensivists are getting to grips with quality in their fields. The Royal Colleges have taken it seriously.

In the late 1980s government promoted medical and clinical audit in hospitals, trying to extend it from enthusiasts to all hospital doctors. Nevertheless many consultants never became involved, perhaps because they felt that specialist medicine was already working well.

General practice adopted a somewhat different approach. The Royal College of General Practitioners had been founded in 1952 to set standards in general practice where none existed. The College introduced vocational training in the 1960s and with that a whole system approach founded on the use of explicit professional standards, supportive education and management and performance review in the new teaching practices. The intention was that young doctors would be placed only with teachers who were role-models of good general practice. In developing its ideas the College looked outside medicine, particularly to the social and behavioural sciences, to education and to the North American quality movement. It paid great attention to the quality of the doctor–patient relationship, to communication and to professionalizing teaching. It strengthened the patient focus by forming its own patient liaison group and encouraging patient participation in practices. By the late 1980s the College had developed quite sophisticated methods for clinical audit and the assessment of medical performance.

So it was that a new culture emerged within general practice that came closer to the public expectation of doctors. This culture was given further form when the GMC began developing its new approach to professional standards—*Good Medical Practice*[17]—and the assessment methods for its 'performance procedures'. And it helps to explain why revalidation has been seen positively by a major segment of general practice.

The drawback of these initiatives in both specialist and general practice was that they were essentially voluntary, so they did not touch poorly performing doctors. Furthermore there was another difficulty. By 1995 we knew that the system of medical regulation was the wrong way round, at least in terms of the needs of contemporary practice. It rested on a central GMC which acted only on complaints. As Rosenthal[18] in her studies in the NHS in the early 1990s demonstrated, there were no well-founded local arrangements at the point of practice—either professional or managerial—for ensuring good quality practice, or for systematically identifying and managing problem doctors[19].

Which brings us right up to date. It was the vivid portrayal of the Bristol tragedy—all those children and parents, real people, not statistics or cases—that drove the message home, assisted by the dramatic media presentation which compelled everyone to listen and act. The new Labour Government constructed its legislation and arrangements for the NHS around the theme of quality and safety. The GMC published *Good Medical Practice* in 1995, and its new performance procedures came into action in 1998. And by that summer it was clear that the regular

systematic assessment of doctors' performance was now essential to give patients proper protection. Revalidation of doctors' registration is the instrument for making this happen. A majority in the GMC and the Royal Colleges were determined that this should happen. The hospital specialists' and public health doctors' committees of the BMA were disappointingly negative. Fortunately the profession is now coming together in a more positive consensus around this proposal.

The principles of quality improvement

The principle of quality improvement is that quality is achieved across a broad front by a process of incremental improvement and that, rather than inspecting out defects, one gets things right first time. If one takes the apples-in-a-barrel metaphor, quality improvement ensures that the barrel contains many good apples whereas quality control seeks out and removes the bad ones. Independent, comprehensive data are essential to illuminate performance, to help explain unexpected variation and to enable people to make choices. Patient experience and expectation have to be an integral part.

In a 1992 review of the quality movement in the UK[20], Professor Liam Donaldson and I emphasized that future success would depend on achieving a satisfactory blend of the professional, managerial and patient perspectives, and on gaining the commitment of health professionals themselves. Each element is important. Good results cannot be achieved if one element is missing. Structures, systems and data are only as good as the people who operate them. So professional and institutional culture—the attitudes of people and their organizations—is the starting point.

In its modernization programme the Government has institutionalized the various elements of continuous quality improvement (CQI) and quality assurance[21,22]. Thus we have the National Institute for Clinical Excellence (NICE) and SIGN Guide in Scotland, creating national clinical guidelines. Clinical governance should be the application of CQI management practice to clinical processes, particularly in clinical teams. The principle of external review is embodied in the Commission for Health Improvement in England and Wales, and the Clinical Standards Board in Scotland. The National Service Frameworks provide a management instrument for seeking optimum results in priority clinical areas. There are specific quality-directed activities such as the proposed system for recording critical incidents described in *An Organisation with a Memory*[23]. And the new National Clinical Assessment Authority[24] in England will enable a local assessment of doctors who may be underperforming. These measures, and the profession's own methods, only make sense if one sees them as a mosaic in which each part has a distinct and well-defined function. Good coordination and communication will be essential to make sure that the system is a light touch rather than oppressive and bureaucratic.

So will all this live up to the rising tide of public expectation? It is a good start, but highly dependent on the manner and style of implementation. Here are four areas of concern which need early discussion and resolution.

First there are conflicts within the Government's policies. Is the quality agenda essentially about continuous quality improvement, the philosophy of which is predicated on a no-blame culture, on helping people to achieve, on helping them get things right first time, about making sure there are lots of good apples in the barrel? In the Government's documentation that is the stated intention. But the obsolete quality inspection mode—root out the bad apples—bubbles through incessantly in ministerial statements and actions, creating the perception that this is the primary objective, important though it is. The result is the impression that the blame culture—for which the NHS is infamous—is alive and well. So how are these to be reconciled? Two examples illustrate the conflict that has to be resolved. Is the Commission for Health Improvement there primarily to identify and accredit quality, or to act as an NHS troubleshooter for institutional dysfunction—the hit squad? Similarly, is appraisal for doctors essentially about formative development and improvement, including the provision of a safe haven in which genuine but unsubstantiated doubts about practice can be discussed, or is it an annual assessment, like the annual pass or fail test for old cars? There are two legitimate functions in both these examples. Both are necessary. But when multiple functions are combined inappropriately in the same method, there can be confusion of purpose and an outcome that satisfies neither. Indeed, instead of encouraging people to come forward, the perverse effect could be to encourage collusion and lose the opportunity for reducing clinical error.

Second, the medical profession has to decide explicitly to adopt the notion of improving quality, and make it work. In practical terms this means abandoning the tired rhetoric of good intentions in favour of demonstrable delivery[25], particularly on the assessments needed for the robust revalidation the public expects.

Third, both the NHS and the medical profession need a positive attitude to working with patients and the public as equal partners on quality. This is a key part of the cultural change. We have already discussed doctors' paternalistic tendencies. But what would be equally unacceptable would be to exchange this for managerial paternalism, a flavour of which comes through in the *NHS Plan*[26]. Consider the attitudes displayed in the proposal to abolish the independent-minded community health councils (CHC) in

favour of what comes over as management-controlled patient advocates.

Fourth, the nub of clinical governance is at the level of the healthcare team. The GMC 1998 booklet *Maintaining Good Medical Practice*[27] sets out exactly what this means. The more effective clinical teams become in managing the quality of their own care day-to-day, and demonstrating their results, the safer and better care will be for patients and the lighter the need for external review. More explicit support and understanding from the higher reaches of the NHS and Government is needed—an understanding of what governance means in practice, what is involved, and what resources are required; for example, to ensure that essential tools such as training for appraisal are put in place without delay. Layers of heavy external regulation are no substitute for enabling mechanisms that can operate swiftly and cheaply within the institutions.

Lastly, the Government will have to decide whether the model of 'command and control' really has a future in modern healthcare. Can a centralized bureaucracy led by a Minister of the Crown be both standard setter and near monopoly provider? There has always been a conflict of interest. This is likely to become more obvious as the information revolution leads to demands from the public for robust independent data on standards and performance, not modified or interpreted by political imperatives or polemics. Where achievement falls short of expectation, the gap must be made plain to allow exploration, explanation and remedial action. Without separation between regulators and providers, none of the parties will be sure that they know the real size of the gap between expected performance and real performance. There are clear implications in all this for the accountability of the regulators—the bodies regulating the individual professions, NICE and CHI. In my opinion it should be Parliament. The regulation of healthcare, linked so closely with safety for patients, merits a new parliamentary mechanism combining the expertise of both Houses.

PROFESSIONALISM

Professionalism is at the heart of doctors' relationships with patients and the public. People normally associate professionalism with quality. It suggests expertise and reliable, consistent performance.

Professionalism in medicine has been based loosely on the Hippocratic Oath, which today looks inappropriately doctor-centred. In modern medical practice, professionalism has been most closely identified with scientific and clinical knowledge and skill unique to its practitioners. In the 1960s and 1970s doctors' views predominated in the consultation—the central professional act. Clinical autonomy was the over-riding doctrine.

In the past 20 years that view of professionalism has been fading. More people wanted openness from doctors, and explicit accountability[28]. Moreover the continuity and intensity of the one-to-one relationship has given way in many circumstances to a more diffuse relationship and the need for some collective as well as personal responsibility with the development of clinical teams. Social changes in medicine itself mean, some would say, that it has become much more of a job and much less of a vocation. More doctors think of part-time working or of a portfolio of interests and activities of which medicine is but one.

Does this spell the end of professionalism? Not if the medical profession listens to what people are saying and is responsive. At heart, people want to be able to trust their doctors, but on much more open terms. The alternative is clinical micromanagement by contract and protocol, a glimpse of which we have seen in managed care in the USA. All but the most ideologically opposed critics of doctors believe that professionally led regulation offers the best chance of securing consistent practice day-to-day, provided that it is firmly directed to patients' interests and vigorously implemented. This is the Government's stated view. Professionally led regulation is predicated on the fact that the practice of medicine still involves a considerable degree of judgment in the fundamental functions of diagnosis and decisions about treatment. Consequently patients, in the privacy of the consulting room, are still critically dependent on their doctors' getting it right first time, knowing the limits of their competence and their honesty and integrity. Doctors practising within a regulatory framework of professional values and standards—professional conscience—are more likely to give of their best for their patients than doctors who are not, because there is peer pressure to do so. In the total perspective, the public has to remember that the great majority of British doctors are like that—conscientious, effective, caring and working far harder than they have contracted to.

Compare this with the teaching profession in the UK. OFSTED (Office for Standards in Education) deals with the bad apples and has had real successes—but at the cost of alienating many good teachers. There has been little to motivate teachers themselves to drive up standards across the whole profession. Hence the present Government's decision last year to introduce a General Teaching Council to try to engage all teachers in the basic tenets of professionalism.

TOWARDS THE NEW PROFESSIONALISM

So what can we do? In the past 10 years a new professionalism has been emerging which I am confident will bring the medical profession and the public closer together again. Remember the impact of people such as Ian

Kennedy, the late Margot Jeffries, Margaret Stacey, Rudolph Klein and Jean Robinson, who from the 1980s onwards were quietly insisting that the public's expectations had to be met? Throughout, the lay members of the GMC have been hugely influential, especially since their voice increased on the GMC in 1995. And even more recently there has been vast pressure on the profession, expressed most directly from groups of parents and patients who have been damaged in medical disasters. The focus for change has been on the GMC, which at one level has epitomized the worst characteristics of our professionalism and at another has become a key driver of the new.

To achieve the new professionalism we have to change the basis of professional regulation so that the whole profession—not just those who want to—performs as reasonable people expect. The GMC, working in partnership with the Royal Colleges and the university medical schools, which are the other standards bodies, has a coherent strategy for achieving this. Let me set out what the key features are.

Standards

I have already referred to *Good Medical Practice*. This is the template, the foundation on which all else rests. It describes the duties and responsibilities of doctors, agreed after extensive dialogue with both the profession and the public. It represents the consensus around which we can all come together.

Good Medical Practice, and the interpretations of it produced by the Royal Colleges for their own specialties, answered the questions the public has been asking, particularly about attitudes, competence, the duty of doctors to protect patients and so on.

The new guidance on consent shows the new approach precisely[29]. It sets out clearly that doctors have a duty, which goes beyond the law, to make sure that they have the patients' (or in the case of children, the parents') permission for whatever they are proposing to do. Ask the patient. That absolute requirement can raise difficulties, as illustrated by the concerns raised about the protection of the cancer registries. The way forward in these situations, where there are conflicting objectives which are both in the public interest, is for the medical profession and Parliament to define the exceptions. What would not be acceptable would be to use the exceptions as an excuse for slipping back into the old ways.

Education

Medical education is the principal means by which the culture of the profession is actually delivered. The GMC will be vigorous with its partners in making this happen. So, for example, a new edition of *Tomorrow's Doctors* later this year will strengthen learning and teaching about attitudes, communication, ethics, team-working and quality improvement, putting these on an equal footing with traditional scientific and clinical expertise. Much progress has been made already, since the first edition[30] set the direction of travel.

These principles have to be reflected equally in specialist training and continuing professional development throughout life. We will be starting new discussions with the Royal Colleges and the universities about how best this might be done. These discussions will extend to the Government's new Medical Education Standards Board when it is set up.

Assessment

As all educators know, assessment is one of the most powerful levers for change. It signals, to those who are being assessed, what it is that really matters.

In the recent work on revalidation, the GMC has made it as plain as possible that assessments that are relevant to a doctor's registration must cover the ground set out in *Good Medical Practice*. That covers attitudes to patients, communication and honesty as well as technical competence. So we will be working with the universities, the Royal Colleges, the National Clinical Assessment Authority and employers and managers—indeed any who have responsibilities in this—to make sure that this happens at all relevant points in the doctor's journey through practising life.

It means much more joined-up working and research on methods of assessment which can reliably tackle questions of attitude and performance. Britain, and specifically the GMC, has a good record of expertise in this field. We plan to better coordinate our efforts because of the common thread that has now emerged, so that even better results can be achieved in future.

Registration

The GMC has converted registration from a bureaucratic listing process into doctors' living contract with patients. So we now have to make sure that when doctors join the Medical Register, whether they have qualified at one of our own medical schools or have come in from Europe or the wider world, they have the qualities and competencies described in *Good Medical Practice*. That means there will have to be further adjustments to the assessments made, particularly of doctors from overseas.

For doctors who are already on the register, there will be regular assessments throughout professional life to show that they remain fit to practise—revalidation again. Crucial linkages are being made with clinical governance in both the NHS and the private sectors so that regular information about a doctor's performance can be fed into the revalidating process.

Problem doctors

It will be clear from what I have just said that the main thrust of medical regulation in future will be in helping good doctors to remain good—and indeed to become better. But problem doctors have to be managed. The GMC is in the middle of a major overhaul of its 'fitness to practise' procedures with the intention of making them simpler and as fair, transparent and effective as possible in protecting the public from the dangerous and the wicked. The GMC intends that the inherent conflict of interest that can exist between the bringing and hearing of cases should end. In my opinion the GMC must continue to bring the actions against those who breach the agreed standards—it should be the guardian of the standards—but the machinery for hearing cases should be at arm's length or perhaps separate altogether.

Reshaping the GMC

To take this strategy forward requires a new kind of GMC. Consultations are being held at present about its future composition and governance. Everyone is agreed that its primary function is the protection of the public. To that end the new GMC will have to represent much more of a partnership between the public and the medical profession on all aspects of professionalism.

Communication

I want to mention communication specifically because we have not been as good as we should have been, either in one-to-one relationships within clinical teams or collectively as a profession. That is certainly a just criticism of the GMC.

As a profession we have been used to a dialogue primarily with the State and between ourselves, and not with the public. This narrow view will have to change. The medical profession needs to develop the habits, strategies and tactics for engaging the public directly. It must become able to explain how medicine works, its limitations as well as its potential, and to find more common ground with the public on what is important and where respective responsibilities lie.

In a similar way it needs to develop better communication with and respect for managers, to understand the pressures and constraints upon them. Doctors and managers together have to make the system work for patients. Only by working together and helping each other can they start to do so.

The Royal Colleges and universities

Lastly, I want to mention the future leadership role of the medical schools and the Royal Colleges. We need the medical schools to become major regional foci for the development of our professionalism, for the demonstration and facilitation of excellence—not just in education but in the models of good practice that should underlie it.

Equally, the Royal Colleges and Faculties, independent as they are and should remain, are the ultimate repositories of knowledge and expertise about their disciplines. From initiatives that already exist, we can expect this to become more refined and focused. But they have the opportunity now to send a very strong signal of their intent to the public by making their memberships and fellowships in future become open-ended demonstrations of excellence for members who are in active practice. The RCGP is exploring this through its 'membership and fellowship by assessment'. With the statutory underpinning of good practice now near, through revalidation, the Colleges have an unprecedented opportunity to become the guardians of excellence in their respective fields.

CONCLUSION

The relationship between the medical profession and the public is changing, and the professionalism of doctors must evolve accordingly. What has not changed is the fact that the public need doctors who are knowledgeable and skilled, ethical and committed. The system of professional regulation is itself evolving to deliver the new professionalism. It must be firmly grounded on the public interest—a partnership between the public and the medical profession.

The Government, the health professions and health service management should together embrace wholeheartedly and unequivocally the practice and habits of continuous quality improvement. The Government must make up its mind whether this is what it really wants. If so, it must signal this clearly and act accordingly both in terms of its style of implementation and in terms of its investment policy. The medical profession has the talent and the ability to give strong leadership.

The environment for care is as important to quality as the performance of those who deliver it. Government, as the principal provider through the NHS, has an obligation to invest in the service at a level that will achieve the quality now demanded by the public. Specifically, the staffing and therefore the capacity of the NHS must be such that health professionals can provide the service expected of them. This must include proper time for the patient, proper time for professional development, and proper time for those other activities intrinsic to continuous quality improvement. Without this they cannot succeed.

In the shifting relationship between the public (as recipients of healthcare), the employers and the health professionals, ways should be sought to make sure that patients, their relatives and their carers have sufficient

information, sufficient choice and sufficient autonomy to feel that they are effectively in charge. Openness, inclusiveness and transparency are key qualities of effective regulation. These should be reflected in the practice of all regulators; and all regulators should be independently accountable to Parliament.

Some people will be embarrassed, even angered, by my history of the events that brought us to this point and the messages that I have drawn from it. But as a profession and as a country, we have to be open about these matters. If I may take the medical analogy, with patients and carers we have learnt the importance of sharing knowledge and experience, to help them understand what is happening to them and the options for treatment. Particularly when people have been hurt by failures in systems or individuals, honesty is the best policy. The same process of honest discussion and communication should apply to those who are affected by the current crisis in the health service, be they public, professional, healthcare worker, politician or manager. What we, like patients, want to ensure is that the appropriate lessons are learned. We cannot have that without analysis and investigation. Reconciliation and the drawing of a line can only begin when we have shared this experience and frankly acknowledged what really went on.

It is through such debate that we can move forward. As doctors our foremost ethical duty is to serve our patients and the community to the best of our ability. The same duty falls on politicians and managers, even if their ethical codes are a little less well defined. We have to start respecting and understanding each other's values and motives. We may then begin to trust each other.

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